## Public Input [Section 505(a)(5)(F)] and Grant Recommendations

Public input to the FFY 2001 Title V Report and Application was provided by a broad range of stakeholders, which included health care providers, local and State agencies, community groups, families, and advocates. (Please see Needs Assessment Process, Section 3.1.1.) Input was sought by CMS at meetings attended by populations served by Title V programs and their families, such as Early Start meetings, and at presentations to groups of health care providers, such as intensive care nurses and nurse managers. A combined MCH/CMS stakeholder meeting held in October 1999, provided an opportunity for discussion of the health status and health care access measures in the statewide needs assessment as well as the priority needs. A presentation on the Title V process and requirements at the MCH Annual Conference held in June 2000 provided MCH professionals an opportunity to discuss the preparation and contents of the Title V document. The local needs assessments prepared by the County and municipal MCH programs were integral components of the needs assessment. CCS and CHDP program directors and deputy directors were surveyed by CMS for the identification of priority needs.
Comments submitted to CMS after distribution of the FFY 2000 Application and Report presented valuable material and raised pertinent issues for the needs assessment and preparation of this year's document.

Comments were received from individuals representing the American Academy of Pediatrics, the California Children's Lobby, the Child and Adolescent Health Policy Board, the Los Angeles Department of Health Services, State CHDP staff, and the Medi-Cal Policy Division. Some of the specific issues raised and their incorporation into this year's Application and Report are summarized below:

1) Given the diversity in California information should be provided on ethnic groups other than White (non-Hispanic), Hispanic, Asian/ Pacific Islanders, and African-Americans. Where available, information on other ethnic groups, such as American Indians, Filipinos, and distinctions among Asian and Pacific Island groups has been included in the FFY 2001 report. This more detailed information will be considered in health service and policy decisions.

2) While infant mortality has improved overall, there are still subgroups, such as African Americans, who deserve additional effort to close the gap in their infant mortality rates. Eliminating racial and ethnic disparities in infant health and mortality has been chosen as a California Title V priority. Considerable efforts are underway to eliminate disparities in black infant health including the Black Infant Health program.

3) CCS needs to be strengthened and eligibility expanded to improve access for children with severe health needs. Outreach to improve delivery of health care for CSHCN and improvement in access to specialty providers have been made Title V priorities.

4) Coordination between CCS services and other health programs needs to become as seamless as possible. Improved coordination with other health program to facilitate

delivery of health care to CSHCN is a State priority. Expansion of CMS Net and linkage with other health information systems should greatly improve service delivery.

Other points raised concerned: clarification of which performance measures were Federal versus State; clarification of the budget discussion; explanation of the purpose of any memoranda of understanding (MOUs) that are mentioned; clarification of program eligibility; better indication of how performance measure numerators and denominators were derived; and comments on how Title V programs function in a specific county.
/2002/ The draft of the FY2002 Title V Application/Report was posted on the website of the California Conference of Local Directors of Maternal, Child, and Adolescent Health, www.CCLDMCAH.org, to facilitate public review and comment. Letters were sent by the MCH and CMS Branches to their stakeholders to inform them of the availability of the document, how to access the document, and to invite public comment. Hard copies were also made available upon request.

Comments in response to the draft FY2002 application were received from project directors in battered women's shelters, county MCAH, CHDP, and CCS directors from the northern and southern parts of the state, breastfeeding advocates and Breastfeeding Advisory Committee members. Their comments focused on the data presented in the Federal and State Performance Measures and the Health Status Indicators and the program descriptions. Lack of progress in specific areas was noted along with questions regarding what further interventions may be needed. The need for further explanation of the annual objectives was indicated; in particular, the basis for revisions of future year objectives was not apparent in the summary. The importance of working with health care providers in identifying victims of domestic violence was also highlighted. A number of readers indicated the value of the document in providing a statewide overview of MCH/CMS programs and indicators.

/2003/ An abridged draft of the FY2002-03 Application/Report which included key updates to the full report, including data tables, was posted on the MCH Branch website for review and comment. MCH partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft. The CMS Branch made the draft available to its stakeholders by faxing an information notice identifying the MCH website as the source for comment of the draft of the Narrative for Fiscal Year 2002-03 Title V Application and Report. This notice went to all County California Children's Services (CCS) administrators, CHDP program directors, deputy directors, medical consultants, and CMS Branch staff, and Regional Office staff.

1. A number of reviewers commented on the data tables. Some individuals requested further discussion regarding marked changes in specific measures in the current reporting year.

    a. Of particular concern to one reviewer was the lack of improvement in the percent of children through age 2 who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus

influenza, and hepatitis B (FPM 05). Additional background information provided to the MCH Branch by the Immunization Branch of DHS was shared in response to this issue.

b. The increase in the maternal mortality rate state outcome measure (SOM) 01 was also highlighted by one reviewer. In response, the MCH Branch's current consideration of the need for a study to investigate the increase in the maternal mortality rate was presented.

c. The unexplained sudden increase in Federal Performance Measure 03 (the percent of CSHCN in the State who have a medical/health home) from 19.3 percent in 1997 to 63 percent in 1998, followed by unexpectedly high variation the next 3 years was commented on. The notes for the Measures were given to the reviewer along with an explanation of why 1998 may have been higher; it was explained that there may have been an error in the numerator as the number of children with a primary care physician was much higher that year compared with other years, using the same method. It is believed that reporting for the past 3 years underestimates the percentage of children with a medical home. This is due in part to the fact that the reporting has not been complete or the families have not identified the primary care physician. Beginning this year there is a specific entry in the CCS registration component for "medical home" and CCS county staff have been trained on the importance of this entry.

d. One reviewer questioned why the percent of Medicaid enrollees under age 1 receiving at least an initial periodic screen (Core Health Status Indicator 2A) under the CHDP program decreased from 84 percent to 72 percent. The CMS Branch explained that this decline may have been attributable to children being transferred to other health care programs, such as Healthy Families, and/or due to under-reporting of complete or partial CHDP preventive health assessments provided by Medi-Cal Managed Care (MCMC) plans.

2. In response to the comments of a number of reviewers, the CMS Branch included additional information on specific programs in the application/report. These include the Medical Therapy, California Connections, and the CHDP Gateway program

/2004/ Comments were received from individuals representing the various MCH and CMS programs and various other stakeholders. Specific issues raised and how they were addressed are summarized below:

1. Local DV agencies had general concerns and/or questions regarding the purpose of Title V, the populations served, and the distribution of funding to state programs, local health jurisdictions, and community organizations. Efforts were made to provide additional information to local agencies. Agencies were also

referred to California's MCH website www.mch.dhs.ca.gov to obtain additional information about Title V programs.

2. Reviewers expressed concern about the lack of emphasis on the Adolescent Sibling Pregnancy Prevention Program (ASPPP), Adolescent mental health services, and the need for increased collaboration with the Department of Mental Health (DMH). In addition to improving collaboration with DMH, California's MCH staff participates in the "Webcast on Adolescent Mental Health"; online seminars sponsored by MCHB/HRSA's Office of Adolescent Health, addressing Adolescent Mental Health Issues and Access to Care. Information about the webcast events are provided to the local health jurisdictions.
3. The CHDP program in Kern County requested information be added to the Preliminary Draft about oral health promotion and treatment services by their program funded by Proposition 10. Among many activities, the CHDP staff provide children with a dental kit with toothbrush, toothpaste, floss, coloring book; they promote the idea of a "dental home", CHDP staff assisting with Medi-Cal or HF Applications; and the CHDP program works with community groups to avoid duplicating services and share plans that work. The response is that if space permits, some of this information will be added to this year's final application. This program will be contacted next year for an update.
4. There were two comments from a CMS Branch CHDP nurse :
    a. "CHDP also mandates anticipatory guidance and health education." This language was added to the final document.
    b. "It would be nice if it was acknowledged somewhere that the HCPCFC is administered locally by the CHDP program, and works very closely with the local CHDP program." This language was added to the final document.
5. One reviewer thought the draft was repetitive across sections; the new format this year will decrease repetitiveness.
6. Reviewers provided additional information for specific programs such as Oral Health and Foster Care, which was incorporated into the FFY 2004 application.
7. Reviewers also made suggestions regarding the integration of interventions and services at the state, local and individual levels, particularly when addressing health disparities in the MCH population. These issues were addressed by the MCH Branch staff and will also be discussed when setting California's Priority Needs for the 2005 Five Year Needs Assessment. //2004//

*/2002/* California's Response to the FFY 2001 Title V Grant Recommendation
Grant Recommendations:

Submit a copy of the current Memorandum of Agreement (MOA) between the California Children's Services (CCS) and the State Department of Education, Office of Special Education and update the MOA between CCS and the State Department of Developmental Services.

A MOA between CCS (Department of Health Services) and the Department of Education has been finalized and approved. A copy is included with this application/ report.

The MOA between CCS (DHS) and the Department of Developmental Services involves a number of complex issues with respect to specific roles and relationships. The departments actively collaborate on providing services to CSHCN but a new MOA has not been finalized.

Describe the Title V efforts to begin, expand or enhance linkages of data with other agencies serving MCH populations, e.g., as referenced in, but not limited to, Form C-3(Data Capacity Information) with Medicaid, WIC, and birth defects surveillance.

The MCH Branch continues to develop its capacity for data linkages through inter-agency collaboration. The Branch and WIC have hired a consultant who will link the WIC data files to the California Birth Certificate Files and the Hospital Discharge Files of the Office of Statewide Health Planning and Development (OSHPD). The linked file will be used to evaluate the impact of the WIC program on infant mortality, morbidity, and hospitalization. Data on infant feeding practices will also become available. The linkage of the 1999 WIC, Birth Certificate, and Hospital Discharge files will be completed by 2002.

The MCH Branch is also working with the Office of Vital Statistics to create an intergenerational birth certificate linked file. The file will link the birth certificates of mothers who delivered an infant in California in 2000 with the mother's own birth certificate if she was also born in California. The main purpose of the data set would be to explore intergenerational factors in birth outcomes, such as the relationship between maternal birth weight and infant birth outcome.

Discussions have been initiated between the MCH Branch and the Medical Care Section regarding the feasibility of linking the Medi-Cal claims files with the birth certificate files. This project will be pursued in the coming year.

CMS Net has already established linkage with the Medi-Cal data system and CMS Net system enhancement related to verification of client eligibility has been carried out. Efforts are in progress to secure a developer for system components related to provider eligibility and authorization of services.

CMS, MCH, WIC, and the Genetic Disease Branch, under the auspices of the Breastfeeding Advisory Committee, are examining the breastfeeding-relevant definitions being used in the completion of the GDB newborn screening form. The goal is to improve consistency in reporting breastfeeding rates upon hospital discharge (FPM 9).

The feasibility of linking the birth certificate files with the newborn screening files of the Genetic Disease Branch is also being explored.

Describe the impact of Proposition 10 on the MCH populations in the State and the Title V efforts to cooperate, collaborate and coordinate with the Proposition 10 activities at the State and county levels.

Major initiatives are underway at the State and county levels as a result of Proposition 10, the voter-approved initiative that placed a fifty cents per pack tax on cigarettes. The revenues fund early childhood development and anti-tobacco education programs. Proposition 10 approved initial funding of a $40 million plan with several activities that address Title V priorities. These include: expansion of the toll-free Tobacco Cessation helpline, expanded training for child care and child development programs in underserved

areas, funding for health and family support consultants for the child care system, safety initiatives for child care centers, and support of a statewide survey on the health care needs of young children. In January 2000, the Commission unveiled a $14 million statewide advertising campaign on television, radio, billboards, and newspapers, in English and Spanish, to educate Californians about the importance of early childhood development and the risks of smoking while pregnant and around children. Eighty percent of the Proposition 10 tax revenues are distributed to County Children and Family Commissions based upon county birth data. Local MCH Directors and their staff are active participants in the county-level commissions in the assessment of local needs and program development as well as providing technical assistance. Local MCH programs have been actively seeking local Proposition 10 funds to provide needed services to children and families.

MCH Branch staff have been working with the Commission to promote the inclusion of activities at the local level that address Title V priorities. In collaboration with the California Center for Health Improvement, MCH staff prepared publications on oral health promotion and injury prevention to highlight program strategies for the under-five population. The purpose is to educate local decision-makers as they determine where to allocate Proposition 10 funds at the county level. In addition, the MCH Branch has submitted several funding proposals to the Commission for initiatives addressing oral health, domestic violence, and infant health.

The CMS Branch is part of a Commission funded asthma initiative that is targeting children with asthma between birth and five years of age. CMS developed and is overseeing the components that relate to asthma treatment and to early identification and anticipatory guidance through CHDP health assessments. The goal is to assure early, appropriate monitoring and treatment, so that the need for hospitalization and morbidity and mortality related to asthma are decreased. The Chronic Disease and Environmental Health Investigation branches in DHS are heading the community intervention and epidemiological components of the initiative.

Describe the progress of the MCH Branch in negotiating with the Managed Risk Medical Insurance Board, which is responsible for the Healthy Families program, to facilitate the exchange of information necessary to apply GIS techniques, including ways to ensure enrollee confidentiality and privacy.

The application of GIS techniques to the Healthy Families Program is being pursued by the MCH Branch. Meetings have been held to resolve the outstanding confidentiality issues.

/2003/ California's Response to the FFY 2001 Title V Grant Recommendations
Grant Recommendations:

1. Describe specific Title V efforts that will assure cultural and ethnic considerations in the development of systems, programs, and activities to improve the health status of specific populations, including CSHCN.

All program activities in the MCH Branch are designed and implemented with regard to the cultural and ethnic context in which they will be operating. The MCH Branch not

only has program activities that target specific ethnic and racial groups that are at higher risk of poor health outcomes, but also makes cultural sensitivity a cornerstone of every program activity. For example, CDAPP targets Hispanic and African-American women who are known to have a higher risk of gestational diabetes. The AFLP serves a majority of Hispanic, African-American, and Asian women in a culturally sensitive environment.

Many of the surveillance and monitoring activities of the MCH Branch include racial and ethnic analyses of program-relevant issues. Data analyses are based on statewide surveys that are supported by the MCH Branch, including the MIHA and the CWHS, as well as program-specific databases, such as that being developed for AFLP; program evaluations such as the BIH evaluation; and ongoing monitoring systems such as the IPODR and the Perinatal Profiles. Race and ethnic-specific analyses of SIDS rates, breastfeeding practices, and folic acid supplement use been reviewed in the development of program activities.

The California MCH Program has developed culturally competent "Back to Sleep (BTS)" campaigns to meet the needs of the Latino and African American communities in response to the documentation of an absence of any decline in the SIDS rates among these communities. California's BTS campaigns, in particular the culturally specific campaigns, have served as models for the national BTS campaigns as well as for several other states. The African American BTS campaign has received California and National awards for innovation. Moreover, several of the SIDS Program's culturally competent training curricula are used by other state SIDS Programs.

Reaching the culturally diverse communities that work with the Title V agency has required the identification of appropriate channels for communication at the local level. For example, to expand outreach to the African American community, staff working with CDAPP have partnered with local churches and beauty salons to increase diabetes awareness. Local radio broadcasts also have provided an important channel for health promotion to immigrant communities.

The development of new partnerships has been central to Domestic Violence outreach activities. In response to infant mortality and morbidity data and DHS surveys, as well as anecdotal information from battered women shelters' staff, which indicated that priority populations, particularly communities of color and youth, were not being adequately served by the existing programs, additional State resources were allocated to DV programs in 1999. These resources were used to fund 15 domestic violence pilot projects that would identify innovative and alternative strategies for improving access among these populations. The projects have reached African American, Native American, Latino, Korean and other Asian-American communities. Partnerships have been established with local non-profit community-based organizations and government entities. These agencies enhance DV programs through their capacity to address the unique cultural differences, traditions, beliefs, and languages that should be taken into account in working with these populations.

One early challenge facing the partnerships was the identification of the appropriate forum for the discussion of family violence. In some immigrant and refugee communities, opportunities were identified in response to requests for parenting classes that would provide alternatives to corporal punishment and promote healthier communication between parents and adolescents. In another project, working through faith-based organizations was identified as the best strategy because of their stature within the African American community. Adopting that strategy required capacity-building in terms of education and awareness-building among pastors and lay personnel. The ultimate goal of these initiatives is to create replicable models using partnerships between shelters and community organizations as a public health strategy to increase *access to shelter*-based domestic violence services that are culturally appropriate.

In many ethnic communities, one of the most important partnerships in effective disease prevention and treatment is that between the health worker and the client's family. Understanding and working with the traditional family support systems in times of stress, AFLP caseworkers have assisted pregnant teens to stay in school in the case of one Mexican immigrant adolescent, and adhere to intensive medical management of a health condition, in the case a Hmong teenager whose family was skeptical of Western medical care.

Local MCH staff must respond to the changing cultural composition of the communities they serve. As some local economies falter while others grow, immigrant populations may shift to new areas. In one Northern California County, the Perinatal Services Coordinator (PSC) surveyed all Bay Area maternity services to collect patient education resources in Vietnamese in order to create an index of available materials. She then recruited a Vietnamese-speaking Support Service Worker to improve access and services within the clinic and to participate in a monthly Asian providers' network meeting. The PSC met with community-based Asian service providers to exchange information about available women's health services.

The CHDP program serves infants, children, and adolescents from diverse ethnic groups, providing low income and uninsured populations with health assessments, screenings, immunizations, and health counseling. For FY 1999-2000, at least 83 percent of the children in the CHDP program were non-White. The CHDP program serves these diverse population groups as both a preventive health care safety net and as a conduit into government assisted health care programs. This conduit will greatly enlarge as the CHDP Gateway program is developed to maximize the number of CHDP children who enroll in Medi-Cal or Healthy Families. Information on the CHDP Gateway will be available in multiple languages so that the maximum number of families will have information about the program.

The CCFC funded Childhood Asthma Initiative (CAI) includes a demonstration project that provides asthma treatment services consisting of outpatient visits, medications, and medication administrative devices to eligible children from birth to five years in the communities of Los Angeles, San Diego, and Oakland. Services are provided through eight participating clinics to ethnically diverse communities with children at risk of

acquiring asthma. The Asthma Treatment Services Program of the CAI, administered by the CMS Branch, has reported that, for March 1, 2001 to March 31, 2002, 62 percent of the children served were Hispanic, 25 percent were Black, six percent were Asian/Pacific Islander, three percent were White, and the remainder were other race/ethnicities.

Several of the CCS and CHDP forms/brochures/letters are already available in languages other than English. Other documents are being translated or soon to be translated into different languages. The multiple letters sent to families of children enrolled in CCS are available in Spanish. Following the revision of CCS program forms, brochures, and letters by Family Voices to make them more family-centered, these documents will be ranslated into multiple *languages.* Some examples of CHDP and CCS documents in languages other than English are: the CHDP Eligibility Information Form in eight languages; a flipchart for health care providers to educate families about obesity under development in Spanish; a brochure on anemia prevention in six languages; the series of 15 brochures on "Growing UP Healthy" for varied age groups in Spanish and being translated into Vietnamese; the "Family Handbook: What Parents Should Know About CCS" in Spanish; a CHDP program informing brochure on "Medical and Dental Health Check-Ups" in nine languages; and a brochure on "How to Prevent Baby Bottle Tooth Decay" in five languages.

2. Describe endeavors to enhance the Title V program by including a broad range of families in activities and program efforts and developing policies for providing reimbursement to families for their involvement.

The MCH Branch partners with local health departments and community-based organizations for program planning and implementation. The involvement of families and consumers is standard practice among the local partners. At the Branch level, consumer and family input has been built into regular program activities. Examples include the adolescent health planning process, the School Health blueprint, the SIDS Advisory Council, the BIH program, and AFLP.

Over the past four years, the CMS Branch has partnered with the University of Southern California (USC), University Affiliated Programs (UAP) under the Title V Block Grant to administer the Community Integrated Service Systems (CISS) Project, "A CISS For California's Children: Developing Partnerships to Integrate Services for Children with Special Health Care Needs (CSHCN)". The goal of the project has been and continues to be to promote the adoption of family-centered policies and services within the CCS program. The project has brought together a State-level Advisory Team that has looked at policies and best practices across state agencies.

During the grant period of October 1997 through September 2001, a series of interactive, skill-building workshops on family-centered care (FCC) was conducted by the CMS Branch and USC UAP staff, in collaboration with Family Voices, Family Resource Center Networks, Regional Centers, and other community-based organizations serving CSHCN. County CCS staff attended the workshops, which served as a forum for sharing information, building collaboration, and developing local action plans for the implementation of FCC practices in the service delivery system. The CMS Branch and

USC UAP staff also provided technical assistance and support to some county CCS programs in implementing their FCC action plans.

In July 2001, staffing standards for county CCS programs were revised to include a position for a parent liaison at the county-level. To date five counties have filled the positions and nine counties are exploring mechanisms for approval of the position. In an effort to support counties toward filling the parent liaison position, the USC UAP and the CMS Branch are assembling a list of parent liaison activities that could be utilized in the development of job descriptions. Also in the draft stage is a training curriculum that includes all training materials and group activities utilized and tested as the CISS Project conducted training over the past five years. This training curriculum will be given to each county CCS program. Also released in 2001 to county CCS programs was the Parent Handbook describing the CCS program.

The CISS project is currently writing the final report which will document the experience of the Parent Liaison at the state-level, working in the Title V program. This report will describe barriers and lessons learned, and will be disseminated statewide and nationally. The Parent Liaison, employed by the USC UAP but based in the CMS Branch, left the position in January 2000 but has continued to work on the project as a consultant. Although the CMS Branch has not been successful in establishing a state-level permanent position, additional sources of funding will be sought to provide continued technical assistance and training for county CCS programs to further define and develop best practices in delivering family-centered care to CSHCN and their families.

3. Describe the progress of the MCH Branch in negotiating with the Managed Risk Medical Insurance Board, which is responsible for the Healthy Families Program, to facilitate the exchange of information necessary to apply GIS techniques, including ways to ensure enrollee confidentiality and privacy.

The MCH Branch has continued to discuss with MRMIB outstanding issues related to applying GIS techniques to Healthy Families enrollment. The issues of confidentiality have not yet been resolved.

4. Provide an update of the Title V efforts to cooperate, collaborate, and coordinate with the Proposition 10 activities at the State and county levels.

The MCH Branch continues to be very involved with Proposition 10 activities, both at the state and local levels. At the state level, Dr. Robert Bates, Public Health Medical Officer, has worked with the DHS Director's liaison to the CCFC. Several funding proposals have been submitted, both from the MCH Branch and others at DHS. CCFC is involved in a planning process to establish its priorities and determine its fiscal status. Two of the CCFC priorities are promoting children's oral health and mental health.

At the local level, MCAH programs funded by the MCH Branch have been very involved with their local CCFC assessments and funding, through provision of the Title V Local MCH Needs Assessment and Plan to the local CCFCs, as well as in providing consultation and assistance in program development and implementation. Proposition 10

resources have facilitated the initiation of a collaborative assessment and planning process that has convened community meetings to facilitate broader input to program design. This process should contribute to the next Title V Needs Assessment. The leveraging of federal dollars and the Title V Needs assessments carried out by all local MCAH programs provided an access point for consultation between local MCAH Directors and the CCFCs. An informal survey completed by twenty of the 61 counties and municipalities highlighted several activities that were undertaken with Proposition 10 support in the surveyed jurisdictions. These include home visiting programs for families with a pregnant woman or preschool child, oral health promotion, childhood obesity prevention, and child care access. The existence of Proposition 10 funds provides an ongoing basis for dialogue, education of policymakers, and decision-making about the appropriate strategic approach for local programs.

The CAI, administered in part by the CMS Branch, is funded by CCFC to target children with asthma between birth and five years of age. The goal is to identify children with asthma and assure early, appropriate monitoring and treatment that will improve quality of life of the children and their families, reduce the need for hospital and emergency services, and decrease asthma morbidity and mortality. The initiative has enabled the addition to the CHDP program Health Assessment Guidelines of a new section on asthma. This section provides the clinical standards for pediatric asthma health assessments of children from birth to five years served by the CHDP program. Early in 2002, the Guidelines and a Provider Promotional Packet were distributed to 5,225 CHDP providers and program directors throughout the state. The initiative was originally funded for July 1, 2000 through June 30, 2002. The CCFC has recently announced that they will continue funding for an additional two years, through June 30, 2004. The CMS Branch will receive $1.6 million annually.

5. Describe the efforts of Title V to address the current oral health needs of the MCH population, including increasing access to care and eliminating disparities in oral health.

In 2001, the CCLDMCAH adopted oral health as one of its priorities to be addressed by the local directors as part of their strategic planning and by creating an oral health workgroup that meets to address oral health among the MCH population. One of their first projects was the collection of vignettes on oral health problems at the county level. These vignettes also address solutions to the problem and will be sent to the CCLDMCAH leadership to identify needs in California. Also in 2001, the DHS Nutrition Network funded a second oral health project for the development of a brochure and a poster focusing on oral health and nutrition for early childhood. The target population will be women of childbearing age, pregnant women, and their children who are clients under the programs administered by the MCH, CMS, and WIC Branches.

In order to meet the growing demand for technical assistance at both the state and local levels, the MCH Branch has contracted with UCSF for a licensed dentist to serve as its Oral Health Policy Consultant at 0.5 FTE. This consultant has the responsibility to continue to convene the DHS Dental Workgroup that was created five years ago to bring together all oral health staff at the state level to foster collaboration and partnerships in oral health. In addition to the state oral health staff, this group includes representatives

of key private organizations such as the California Dental Association, the Dental Health Foundation, and the CCFC. A concrete example of the continued collaboration was the February 2002 meeting in which DHS, the California Dental Association, and the Dental Health Foundation sponsored the California Oral Health Partnership (COHP) meeting, "Developing an Oral Public Health Infrastructure Blueprint" to develop a new vision for California's oral public health infrastructure. A final document was released in June 200220.

The CMS Branch continues to work toward improving oral and dental health in California's children through the CHDP and CCS programs. The CHDP program dental referrals serve as a gateway for dental care for children of any age when a problem is detected or suspected. Further, CHDP requires annual dental referrals for children. For FY 1999-2000, 1,839,461 children received dental screenings through the CHDP program. Of these children, 67 percent were Hispanic and at least 84 percent were non-White. In addition, Denti-Cal reimburses dental providers for oral exams and necessary dental care beginning at any age for Medi-Cal eligible children. Also, certain oral conditions are CCS eligible medical conditions as stated in the final CCS Medi-Cal eligibility regulations (issued July 2000). Dental problems that impact on a CCS medically-eligible condition are covered as part of CCS case management. Severe handicapping malocclusion continues to be a CCS medically eligible condition. The CCS program has seen an increase in referrals for handicapping malocclusion from Healthy Families liaisons due to an increasing enrollment of children in the Healthy Families Program. The CMS Branch is currently reviewing the CCS orthodontic policies to be more consistent with the Medi-Cal/Denti-Cal orthodontic program.

6. Describe the progress in the development of CMS Net as a means of maintaining the provider network for CSHCN.

The client eligibility function of CMS Net E47, the enhancement to allow CCS and GHPP providers to have the state's fiscal intermediaries pay their claims electronically, is complete and working in CMS Net. The authorization and provider enrollment functions are under development.

A function entitled "Paneling and Approvals" has been added to CMS Net. This function creates a centralized location for CCS provider specific data. The intent of this function is to 1) simplify provider paneling, special care center approval, and hospital approval verification; 2) replace the paneled provider microfiche; 3) replace approved hospital and special care center hard copy directories (Chapter 7); 4) provide frequent updates and timely access to approval information; and 5) allow the CMS Branch and county CCS programs access quickly and readily to information via CMS Net. Counties that are not on CMS Net have been provided CD ROMs with paneling and approval data.

Additional improvements include "Medical Home" is now a unique data field on the CMS Net registration face sheet, and the CMS Net help desk now has a toll free telephone access number to assist CMS Net users with questions and information.

/2004/ California's response to FFY 2003 Title V Grant Requirement and Grant Recommendations.

Grant Requirement:
Within 30 days of the receipt of the award letter, describe plans of the Department of Health Services to appoint a Chief, Maternal and Child Health Branch, with appropriate public health and MCH training, knowledge, skills, experience and leadership qualities, and if this is not a permanent position, describe plans to recruit and hire a permanent Chief.

It is important to the DHS that the Maternal and Child Health Branch be headed by a qualified individual who is capable of providing leadership in this important program area. Accordingly, Susann J. Steinberg, M.D., was appointed as Acting Chief for the Branch effective November 20, 2002 and has the full authority of the MCH Branch Chief position. Dr. Steinberg has many years of experience in the private and public sectors. Dr. Steinberg is Board Certified in Family Practice and Preventive Medicine, with additional training in Obstetrics and Neonatology, making her an excellent choice to serve as Acting Branch Chief.

California continues to struggle with an enormous budget shortfall, which has delayed our ability to appoint a permanent MCH Branch Chief. There is a freeze on State hires, which restricts DHS's ability to make a permanent appointment. In the meantime, the MCH Branch is in very competent and qualified hands under the leadership of Dr. Steinberg.

Grant Recommendations:
**1.** Describe the accommodations being made to account for the cultural diversity of the ethnic populations being served.

Cultural diversity places added demands on the State of California's health care system in relation to both access to and quality of care. In 2003, almost 50 percent of California's Medi-Cal and Healthy Families program members primarily speak a language other than English. To improve access to Medi-Cal services, all Medi-Cal managed care materials are to be made available in ten threshold languages. These include: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

DHS implemented the CHDP Gateway on July 1, 2003, in an effort to provide Medi-Cal or HF health benefits for an estimated 760,000 children in California who are receiving CHDP preventive services but have no comprehensive coverage. The majority of these children are Hispanic (67.4 percent). Only 9.4 percent of this population group is White. All information, applications, and letters related to the CHDP Gateway will be made available in Armenian, Cambodian, Chinese, English, Farsi, Hmong, Korean, Lao, Russian, Spanish, and Vietnamese.

DHS annually conducts the Maternal and Infant Health Assessment (MIHA) Survey to assess the ongoing needs of low income and minority populations by targeting specified zip codes. The survey results guide development of MCH programs at both state and local levels.

At the local level, there are many examples of local communities seeking input from constituency and advocate groups. In San Diego the Mid City Community Action

Network, conducts focused meetings on addressing the needs of the immigrant Somali refugee population in central San Diego. The MCH Director in San Diego also participates in these meetings. Another example of community collaboration is the Multi Cultural Health Promotion Program in Alameda County, which encompasses Oakland, Berkeley, Fremont, Hayward and San Leandro. This program is designed to provide health information that reflects culturally competent care to pregnant and parenting women. In Contra Costa County, the Perinatal Service Coordinator has conducted an Ethnic Diversity Training Day to engage medical and health care providers to provide culturally sensitive care.

The MCH Branch works to provide ethnically diverse staff to recruit clients into care and local jurisdictions operate to employ a variety of unique methods to target diverse populations. The Maternal Child Health program in Orange County utilized matching funding through the First Five program to conduct care coordination for pregnant women and their families. The program, called "Promotores", is employed by the local program to work with Hispanic pregnant women and their families to ensure that they are enrolled in prenatal care and have access to all appropriate services such as WIC and health care for other children in the family. In Madera County, the MCH program was instrumental in developing the Healthy Beginnings Multi Disciplinary Team which focuses on case management for high-risk families with children 0-5 years. The Madera County Extra Special Parents Group, Madera County Schools, Mental Health, and the MCH Program work collaboratively to provide services and case management to these high-risk families to ensure that they stay connected to medical providers and have access to appropriate health and social services.

CPSP strives to increase cultural awareness in its programs by providing multilingual pamphlets and SIDS provides materials in Farsi, Hmong, Lao, Russian, Spanish, Vietnamese, and Tagalog. CDAPP is addressing the needs of California's increasingly ethnically and culturally diverse population by incorporating cultural competency awareness in all CDAPP trainings and materials. Direct services are being provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists. At-risk women, including Hispanic, African American, Asian, Pacific Islander women, their communities, and their providers are being targeted. All regional CDAPP staff participate in cultural competence training and multi-lingual, ethnically, and culturally appropriate education materials are being developed and distributed. For example, CDAPP Guidelines for Care includes a chapter on culturally competent education and clinical care. CDAPP is also targeting organizations such as CPSP, BIH, Latino Health Council, Indian Health Program, Diabetes Prevention and Control Program, Diabetes Coalition of California, and National Diabetes Education Program for collaborations and partnerships. The SIDS Program develops and distributes culturally competent materials to county health care providers and the public through a Long Beach State University SIDS Contractor.

The CHDP program collects ethnicity data by funding source, age, county, and services received. The program perceives this as an important step in planning accommodations for the children being served. The CHDP Health Assessment Guidelines, the practice

standards for CHDP providers for health assessments for children served by the program, contain directives for culturally competent services. For example, providers are instructed to "provide an office environment sensitive to age, social and cultural differences of children and their families". Another example is that for the "risk of injury assessment" the provider is instructed to "supplement anticipatory guidance with culturally competent and relevant educational materials". For health education, the provider is required to "supplement counseling with culturally appropriate educational materials specific to the counseling message". For the "developmental and socio-emotional/behavioral assessment and anticipatory guidance", the provider is required to "integrate information according to cultural background".

The CHDP program will be developing a plan for assisting providers with attaining a culturally competent environment and with implementing the culturally competent clinical assessment. The program will explore having each local CHDP program contact its providers with a self-assessment survey regarding their provision of culturally competent services and care and a culturally competent environment. The goal of the survey will be to determine what is working well, "package it" and "deliver it" to all the over 5200 CHDP providers in California. Another project being considered is the compilation of provider listings for each county identifying provider language capabilities. This listing would be a resource for local programs to assist families in finding a physician who may be able to best relate to the family.

In an ongoing process, the CHDP and CCS programs have been translating brochures and other information resources into some or all of the threshold languages in order to meet the needs of their culturally diverse families. For many years, artwork for brochures and posters has been selected for cultural and ethnic competency. Materials are formatted with the consideration of the diverse ethnic groups. The CCS program, primarily through on-site visits, continues to work with CCS approved Special Care Centers (SCCs) and hospitals to provide assistance and encouragement in the provision of culturally competent care and services.

CCS standards require CCS approved hospitals, pediatric and neonatal intensive care units and SCCs to provide family centered care that includes culturally competent care. This includes having materials and signs in the languages of the patients served, decorations that reflect the cultures of the patients seen, and recognition of the culturally different definitions of the term "family" which can include extended family or tribal leaders who have no blood relationship.

**2.** Revise the ERP to include an explanation as to why Form 7 shows no non-CSHCN children had SCHIP as their primary source of coverage.

Language has been added that states, "Families of children who received State-funded health assessments have indicated that they have no other insurance coverage for well-child care when they completed the CHDP application."

**3.** Clearly articulate the relationship parents and consumers have with the MCH and CSHCN programs.

The 61 local MCAH programs partner with their First Five commission as well as other children and family community collaboratives to assess needs and obtain input from community members regarding their MCH programs.

Most of the CMS Branch efforts in this area have been through the five-year partnership with the UAP under the Title V Block Grant in the CISS Project, "A CISS For California's Children: Developing Partnerships to Integrate Services for Children with Special Health Care Needs (CSHCN)". The CISS Project continues to promote the adoption of family-centered policies and services within the CCS program. It has conducted a Family-Centered Survey of all 58 county CCS programs; data analysis is still in progress. Initial results show that the CCS MTUs are very involved in providing family-centered care.

CCS staffing standards allow county CCS programs to establish a parent liaison position; four counties have each hired a parent liaison. At the request of the CMS Branch, the CISS Project is developing a guide for county CCS programs to conduct training on family-centered care. The CMS Branch and the CISS initiative continue to collaborate on a CCS policy letter to implement family-centered care. An advisory team was created by collaborative efforts from the State CCS program, Family Voices, Family Resource Center Network, the Medical Home Project, and the Children's Regional Integrated Service System (CRISS) Project, in order to promote family-centered care. CCS-approved hospitals are investigating ways to include parents in all levels of care.

The CMS Branch has been collaborating with Family Voices in a two-phase project. In the first phase, completed at the end of 2002, approximately 24 letters/documents used in the CCS application and initial program eligibility process were revised to make them more family-centered and several new letters were created. These letters and documents were field tested throughout California in focus groups consisting of parents, and state and county CMS staff. Following the groups' input the letters and documents were revised, and are currently being translated into 11 threshold languages. In the second phase of the project, approximately 30 CCS program letters and materials related to continuing eligibility will be reviewed by Family Voices and revised to ensure that families easily understand them and that families are fully informed of CCS services and procedures.

CCS has had a policy for many years to pay for maintenance (housing, meals) and transportation (bus tickets, gasoline) for CSHCN and their families. Families often have needed assistance to travel to their designated SCC and in some cases, to stay overnight. Also CSHCN at times require hospitalization, electively or emergently, and often at a distance from their homes; their families may need assistance with travel, lodging and meals. County CCS programs budget for these projected expenses for maintenance and transportation for families of CCS eligible children. County CCS programs also work with hospitals and community agencies that might be able to contribute to expenses for family maintenance and transportation. In addition, county CCS programs work with SCCs, hospitals, and families to cluster appointments so more than one appointment can

occur on the same day or over two days, and in this way assist families with budgeting time away from home and travel time that can be exhaustive.

The Medically Vulnerable Infant Program (MVIP) provides home-based services to high-risk infants who are graduates from NICUs and to their families. The goals of the MVIP are to reduce preventable sequelae, secondary illness, hospitalizations and developmental disabilities or delays. These services are provided by a multidisciplinary staff of nurses, social workers, physical and occupational therapists, infant and child development specialists, nutritionists, speech therapists and pathologists, special educators and other professionals and allied health professionals who are trained to bring an array of family centered services to infants and their families.

The CMS Branch also collaborates with parent representatives and diverse parent groups through the Interagency Coordinating Council for Early Start.

The CMS Branch recognizes transitioning care for CSHCN from pediatric to adult services as an important aspect of family-centered care. Standards for beginning transition services at age 14 years are being added to the CCS standards for outpatient SCCs. Some CCS county programs have been very active with planning transitioning care and other counties are just beginning. In Santa Barbara County, for example, a Transition Committee of CCS staff receives input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions. The committee organizes in-service training and presentations for CCS staff. Current and former CCS clients attend meetings to share their experiences.

**4.** Describe continuing progress in developing partnerships to address healthcare needs of children and families with respect to:

**a.** Titles XIX and XXI re: identification and discussion around challenges and strategies for enrollment of eligible applicants in Medicaid and SCHIP, as well as issues impacting reimbursement and immunization rates, and increasing access to oral health services.

On July 1, 2003 the new CHDP Gateway began with pre-enrollment into Medi-Cal for most CHDP eligible children. Although the Gateway will end after the second month of pre-enrollment for children not found eligible for Medi-Cal or HF, it is a new, temporary, avenue of medical and dental treatment for CHDP children who might not otherwise be eligible for treatment in the Medi-Cal program following a CHDP health assessment and referral.

It is estimated that approximately 760,000 children receiving CHDP services are eligible for comprehensive coverage through HF or Medi-Cal. DHS has developed an electronic "gateway" at CHDP provider offices and clinics that will facilitate the enrollment of eligible children into Medi-Cal or HF coverage. An application for a CHDP health assessment will serve as the pre-enrollment application into HF or Medi-Cal. Eligible children will be pre-enrolled into Medi-Cal for up to two months and receive complete benefits of the Medi-Cal Program. Parents/guardians will be asked if they want to apply for continuing Medi-Cal or

HF coverage and, if required, a joint Medi-Cal/HF application will be sent automatically to their home address.

DHS has put together training modules to introduce CHDP providers to the Gateway. There will be provider trainings held between April 1, 2003 and September 30, 2003 in 17 strategic locations around California to enable as many providers as possible to attend. A satellite video-teleconference of a provider training was held on July 10, 2003 and received at 41 sites across the state. Simultaneously changes have been made to the existing CHDP provider instructions, and a new CHDP provider manual will be issued in late June, just prior to Gateway implementation. Information about the Gateway is also available on the CHDP web site and will be updated periodically, including Frequently Asked Questions.

In addition, the Gateway was introduced to local CHDP program staff in a training session held in Sacramento in late March 2003. Local staff were given the opportunity to discuss their new roles and opportunities for making the Gateway implementation successful. New CHDP program policies, in the recruitment, enrollment, and oversight of participating providers were also introduced in anticipation of the introduction of a Local Program Guidance Manual in the summer of 2003.

To address the challenges around the enrollment of MediCal and HF eligible applicants, Health-e-App has become available to all California Enrollment Entities (EEs). As of April 2003, over 25,000 HF and Medi-Cal applications have been submitted using the Health-e-App. Almost 1000 EEs have signed up to use the online application, and over 300 in 46 counties are currently using it.

The CMS Branch collaborates with the Immunization Branch regarding the Federal Vaccine for Children (VFC) program. This collaboration is important as immunization benefits for the CHDP program continue to change with changing immunization practices in California and the nation. The most recent change was the addition of PediarixTM, a new pentavalent vaccine, as a VFC covered immunization and a CHDP vaccine benefit. The CHDP program provided 4,741,675 individual immunizations in FY 2000-2001, an 8.6 percent increase from the prior year. The VFC program supplies the majority of vaccines for the CHDP program. The average cost of vaccines for the CHDP program includes primarily the administration fee and the costs for the few vaccines that providers must purchase directly.

The CMS Branch also collaborates with the Immunization Branch with representation on the Statewide Immunization Information System (SIIS) Executive Consultative Committee. This committee provides oversight and support for California's statewide immunization registry network. When fully implemented, this computerized system will track patient immunization records and help providers to potentially fully immunize all California children and adolescents. At the State level, the Health Disparities subcommittee works to determine the rationale for disparate immunization rates in African-American communities, and to develop recommendations and/or strategies for increasing immunization compliance within these communities.

Current oral health activities of the CMS Branch include developing the "Orthodontic/Dental Handbook" to assist orthodontists and dentists to better understand the CCS program and accept more CCS children into their orthodontic and dental practices. The CMS Branch is also working with the California Association of Orthodontists to encourage more orthodontic providers to become CCS-paneled and to accept CCS-eligible children.

The CHDP Gateway (described above) provides a unique opportunity for most pre-enrolled children to receive dental services through Denti-Cal for up to two months even if they are not found eligible for Medi-Cal or HF. These dental services will be available to children whose families could not otherwise afford them. In addition, Denti-Cal continues to reimburse dental providers for any necessary dental procedures for eligible children, regardless of their age. Effective April 2002, 10 dental procedures are covered benefits for selected pregnant women enrolled in Medi-Cal. These benefits include preventive procedures such as scaling and root planing, cleaning and some periodontal surgery procedures. These procedures were added based on recently published data regarding a possible association between preterm and low-birth weight babies and periodontal infection.

To improve the quality of dental screenings and to facilitate more precise referrals to a dentist, the CHDP program has recently introduced the "PM 160 Dental Guide" to the over 5200 CHDP providers. This new visual aid is a two-sided full color laminated tool to be used to assess and refer children for dental care. This tool visually depicts the four classifications of treatment needs for a dental referral as identified by the American Dental Association. These guides will assist providers in determining which children need urgent or emergency dental care.

**b.** Collaboration with the Primary Care Association.

The Primary and Rural Health Care Systems Branch has an active and long standing collaboration with the California Primary Care Association (CPCA) regarding the following activities:1)Memorandum of Agreement relating to selected activities within the 2002-03 HRSA Collaborative Agreement. 2) Membership in the PCO (primary care organization-Office of Statewide Health Planning (OSHPD)) and PCA (California Primary Care Association) Committee. Monthly meetings address issues in the Collaborative Agreement. 3) Membership in the Northern Rural Roundtable (a quarterly forum for rural, farm worker clinics). 4)Occasional CPCA legislative update presentations at PRHCSB annual technical assistance conferences held for health clinics holding PRHCSB grants.

CPCA has collaborated with the CMS Branch regarding the development of the CHDP Gateway. The Association has been one of the stakeholders participating on the Gateway Advisory Group. Many of the community health centers that are members of the Primary Care Association are also CHDP providers.

**c.** Collaboration with the State Head Start Association.

The CHDP Program is operated by 61 local health departments throughout the state. The local CHDP program has developed working relationships with Migrant, Early and regular Head Start programs in each local jurisdiction. For many programs this is represented by an interagency agreement that outlines the areas of responsibility including such areas as reviewing the CHDP services provided to children enrolled in Head Start, maintaining program knowledge, and sharing resources for the provision of necessary health care services. In addition, members of the CHDP program staff often serve on the local Head Start Advisory Boards. Head Start also actively participates in the CHDP audiometric training programs. Head Start staff become certified in hearing screening and then offer hearing screenings to children in the Head Start program, as well as provide follow-up.

**5.** As a result of California's active participation in crafting its Oral Health Blueprint, it is recommended that the State MCH program describe its efforts to implement MCH specific recommendations that arose from the Blueprint.

To further implement California's active participation in addressing the Oral Health Blueprint, the MCH Branch dental program is working in collaboration with the Dental Health Foundation on addressing the oral health needs of young children in California through a federal grant from the MCH Bureau. The grant addresses the oral health needs of young children in California; four regional workshops will be held throughout the state to train local providers and program staff on key oral health measures discussed and addressed at consensus conferences. The first consensus conference will be held in the fall of 2003 in Sacramento.

The most significant achievements have been in community water fluoridation, which has made slow but steady progress in the last 5 years. In 1998, only 17 percent of Californians had access to fluoridated drinking water. Following the passage of AB 733 in 1995, the cities of Los Angeles and Sacramento were fluoridated in 1999 and 2000. In addition, there was voluntary fluoridation in Mountain View, Pico Rivera, Yuba City and Port Hueneme. The Helix Water District in San Diego County, the city of Escondido, the San Francisco Public Utility Commission and Daly City have all begun the process of constructing fluoridation systems and are preparing to fluoridate within the next two years. The City of Watsonville is under state orders to comply with the law. Today, almost 30 percent of Californians have access to fluoridated drinking water. Finally, the Metropolitan Water District of Southern California recently voted to fluoridate their 5 treatment plants, which will add an additional 18 million people (but not all optimally fluoridated) to the numbers noted above and will move California to somewhere approximately 60 percent of residents having fluoridated water.

In February 2003, the State Committee for the Protection of Human Subjects approved the study entitled "Xylitol chewing gum as an adjunct to caries prevention measures: a pilot study on compliance in California public health programs". The main goals of the study are to evaluate the implementation of a xylitol caries prevention program in conjunction with a traditional dental health education program in a high-risk population, and to determine the compliance with the use of daily xylitol chewing gum for caries

prevention. The study started in the fall of 2003 in Kern and San Bernardino counties. The target population is approximately 200 adolescent and adult mothers in the Black Infant Health and Adolescent Family Life Programs. The Dental Health Consultant is in the process of writing an application to the UCSF CAN-DO Center for Health Disparities and to the California Dental Association Foundation to obtain funds to partially fund the project.

First Five will soon release a $10 million dollar RFA to address children's oral health issues. A total of $7 million dollars will be allocated to fund public education and train dental and non-dental health care providers on the importance of oral health for early childhood. The remaining $3 million will be contracted out with MRMIB. The MCH Branch has been actively working with interested agencies and organizations such as the Dental Health Foundation and the California Dental Association to make sure MCH-related oral health activities and programs will be a part of this initiative.

Toothbrushes and children's fluoride toothpaste have also been distributed to local MCH programs including Adolescent Family Life Program, Black Infant Health, and CPSP as incentives and education tools. In the fall of 2002, the MCH Oral Health Policy Consultant, MCH Nutritionists, Pediatric Consultant and members of the DHS Dental Workgroup developed oral heath educational materials. The final draft is currently under approval by the DHS Director.